

9012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, Rural				c. LENGTH OF STAY IN 1b 17 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, Rural				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			
3. NAME OF DECEASED (Type or print) First Arthur Middle Arnett Last Armour				4. DATE OF DEATH Month August Day 8 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1887	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage Owner (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cecil L. Armour				14. MOTHER'S MAIDEN NAME Sarah J. Brickley			
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, OR COAST GUARD? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-20-2847B		17. INFORMANT Mrs. Arthur A. Armour, North East, Md. (Rural)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Carcinoma of Both Lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 10 1959 to Aug. 7th , 19 59 , that I last saw the deceased alive on aug. 7 , 19 59 , and that death occurred 6.45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED							
ACTUAL SIGNATURE R.C. Dodson M.D.				PHYSICIAN'S NAME (Type) Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-11-59		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Rising Sun (Rural) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE AUG 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8998 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pa. b. COUNTY Lancaster					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, MD			c. LENGTH OF STAY IN 1b visiting	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster <div style="text-align: right;">75 x - 3</div>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				d. STREET ADDRESS 524 St. Joseph		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle J Last Bertz				4. DATE OF DEATH Month 8 Day 21 Year 1959					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.T.R.S.S. Bertz Co.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lancaster		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sheldon S Bertz				14. MOTHER'S MAIDEN NAME Bertha Ritchie					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. W.S. Sullivan, Lancaster, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Roll Dodson EXAMINER'S NAME (Type) J. C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Personal Aug 24, 1959		Aug 24, 1959		St. Joseph - New		Lancaster Penna			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin Funeral Home W. A. Lusby Elkton Md.				24a. REC'D BY REGISTRAR 25-92, Main St.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans		24c. DATE AUG 25 '59	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17
 1938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1893		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Carpenter		High School		Married		Catholic		None		None		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR		MINUTE		DAY		MONTH		YEAR		PLACE OF DEATH		CITY	
1938		10:00 AM		10		00		10		10		1938		Home		BALTIMORE	
SIGNATURE OF EXAMINER		TITLE		NAME		ADDRESS		CITY		STATE		COUNTRY		DATE		TIME	
J. H. HARRIS		Physician		J. H. HARRIS		1234 Main St.		BALTIMORE		MD		USA		1938		10:00 AM	
SIGNATURE OF WITNESSES		NAME		ADDRESS		CITY		STATE		COUNTRY		DATE		TIME		PLACE OF DEATH	
J. H. HARRIS		J. H. HARRIS		1234 Main St.		BALTIMORE		MD		USA		1938		10:00 AM		Home	

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TO FURNISH TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in the "pending" envelope and forward it to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FURNISH TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation or removal.

8999 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08971

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle A Last Bond				4. DATE OF DEATH Month 8 Day 13 Year 1959			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-13-1903		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 10 Days 13 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY cleaning		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bond				14. MOTHER'S MAIDEN NAME Malinda Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 218-09-3618		17. INFORMANT Bertha Brown, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Uremia and Diabetes Injury to Chest ? DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 8-14-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-59		22c. NAME OF CEMETERY OR CREMATORY James Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cokeburg - Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Otelia J. Bullock - Heredon, Md.				ADDRESS Herodon, Md.		24a. REC'D BY REGISTRAR DATE AUG 19 1959	
				24b. REGISTRAR'S SIGNATURE G. W. P. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9013

CERTIFICATE OF DEATH

08972

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Holloway Beach		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 1231-2 d. STREET ADDRESS 76 E. Bel Air Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First G. Middle REXFORD Last BRANDOW		4. DATE OF DEATH Month August Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1899 9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY Dentistry	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Brandow		14. MOTHER'S MAIDEN NAME Emma Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-38-9903	
17. INFORMANT Evalynn Brandow		Address 76 E. Bel Air Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) 1 hour - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1934 , to August 21, 1959 , that I last saw the deceased alive on August 21, 1959 , and that death occurred at 4 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Wolbert, M.D.		ADDRESS (Street, city or town, state) 200 N. Union Ave. DATE SIGNED 8/22/59	
PHYSICIAN'S NAME (Type) Frank Wolbert, M.D.		Havre de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/59	
22c. NAME OF CEMETERY OR CREMATORY Uniondale Cemetery		22d. LOCATION (City, town, or county) (State) Uniondale, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE AUG 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

9013

Name of Deceased		John Doe	
Sex		Male	
Age		45	
Date of Birth		August 15, 1945	
Place of Birth		Baltimore, Maryland	
Cause of Death		Heart Disease	
Date of Death		August 20, 1990	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		August 25, 1990	
Registrar's Office		Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9000

CERTIFICATE OF DEATH

08973

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 55yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas H. Brown				4. DATE OF DEATH August 21 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 16, 1892	
9. AGE (In years lost birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Aerial Product		11. BIRTHPLACE (State or foreign country) Salem, Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George G. Brown		14. MOTHER'S MAIDEN NAME Marion Harlan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-6155		17. INFORMANT Gertrude A. Deibert, Bow St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Acute cerebrovascular accident DUE TO with left hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 16, 1959, to Aug. 21, 1959, that I last saw the deceased alive on Aug. 20, 1959, and that death occurred at 1:45a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.				ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Maryland			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				DATE SIGNED 8/22/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-23-1959		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin				24a. REC'D BY REGISTRAR DATE AUG 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

hours 0

9014

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 2mos 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frantz A. Capps		4. DATE OF DEATH Month Day Year 8 30 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-12
9. AGE (In years last birthday) yrs. 47		10. IF UNDER 1 YEAR Months Days Hours Min. 47X-3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Greensboro, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Capps (Deceased)		14. MOTHER'S MAIDEN NAME Daisy Trollinger (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 578 09 7912	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococcus aureus coagulase positive DUE TO Infection massive region of operative wound (c) disarticulation of right leg		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic gangrene both lower extremities		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-18 , 19 59 to 8-30 , 19 59 and that death occurred at 7:00A AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. Garey		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		DATE SIGNED 8-31-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/2/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		24a. REC'D BY REGISTRAR SEP 4 '59	
ADDRESS Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of California

Death

Washington

June 13 days

Forty Joint, WA

830 Broadway Place, S.F.

Forty Joint, WA

10

10

10

10

James

A.

James

10

10-10-10

James

10

10

Washington, D.C.

Washington

Washington

Forty Joint (referred)

Forty Joint (referred)

Forty Joint, WA

10

10

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

Forty Joint, WA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08975

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 24 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 510 W. Mulberry			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle M. Last DELAUGHTER				4. DATE OF DEATH Month August Day 28 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-95		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 63 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward DeLaughter				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage - fracture of the left temporal bone DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pushed off the steps and hit his head.					
20c. TIME OF INJURY Month, Day, Year 5:30 p. m. 7-28 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. Hospital, Perry Point, Cecil, Maryland		20f. (City or town) (County) (State) Perry Point, Cecil, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Michaelson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/31/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>				ADDRESS Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE SEP 4 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING 18
2015 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10-15-1915	
Place of Birth		Race		Color		Religion	
New York		White		White		Roman Catholic	
Occupation		Cause of Death		Manner of Death		Place of Death	
Carpenter		Heart Disease		Natural		Home	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Signature of Registrar	
10-15-1915		10:00 AM		New York		[Signature]	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08976

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB 17 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS Water St.			
3. NAME OF DECEASED (Type or print) First Enilda Middle Diaz Last				4. DATE OF DEATH Month 8 Day 2 Year 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-23-1958	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 5 Days 5		IF UNDER 24 HRS. Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Elkton, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Diaz				14. MOTHER'S MAIDEN NAME Sally Osborn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Sally Osborn, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Elio enteritis and neglect DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) back and buttocks excoriated and spot on head DUE TO (c) Ulcerated.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 571.0							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8-3-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF AUG 5, 1959		22c. NAME OF CEMETERY OR CREMATORY GILPIN MAJOR		22d. LOCATION (City, town, or county) (State) ELKTON, Md	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS ELKTON, Md		24a. REC'D BY REGISTRAR DATE AUG 11 '59	
				24b. REGISTRAR'S SIGNATURE Robert S. Frank			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]

RESIDENCE: [illegible]
DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE OF DEATH: [illegible]

UNDERLYING CAUSE OF DEATH: [illegible]

PERMANENT CAUSE OF DEATH: [illegible]

DECEASED'S PRESENT CONDITION: [illegible]

DECEASED'S PRESENT LOCATION: [illegible]

DECEASED'S PRESENT STATUS: [illegible]

DECEASED'S PRESENT ADDRESS: [illegible]

DECEASED'S PRESENT PHONE: [illegible]

DECEASED'S PRESENT MAILING ADDRESS: [illegible]

DECEASED'S PRESENT SOCIAL SECURITY NUMBER: [illegible]

DECEASED'S PRESENT MARITAL STATUS: [illegible]

DECEASED'S PRESENT OCCUPATION: [illegible]

DECEASED'S PRESENT RESIDENCE: [illegible]

DECEASED'S PRESENT DATE OF BIRTH: [illegible]

9016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clem Middle S. Last Ford		4. DATE OF DEATH Month 8 Day 29 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-80
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable	
11. BIRTHPLACE (State or foreign country) Alexandria, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clem S. Ford Sr.		14. MOTHER'S MAIDEN NAME Alice Jane Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Not ascertainable	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Unresolved, bilateral 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, right kidney DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-6 days 10-15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, moderately severe.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-6- 19 58 , to 8-29-59 , 19 and that death occurred at the causes and the date stated above. and that death occurred at 11:10 PM from the causes and the date stated above.		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. 8-20-59	
ACTUAL SIGNATURE J. L. Garey		DATE SIGNED	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-19-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. REC'D BY REGISTRAR SEP 2 59	
ADDRESS 1400 Chapin St., NW, Wash, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Hospital of Columbia

Genl

Washington

1 year and
23 days

1947

and his wife, Mrs. J. H.

Administration Hospital

1947

Genl

1-15-50

White

Male

Not ascertained, Washington, D.C.

Black

Alfred James Lee

Alfred E. Lee, Jr.

For recordable Hospital Records, VA, Port of Spain, B.A.

W 1

Yes

Encephalomyelitis, Unilateral, bilateral

2-5 days

Encephalomyelitis, acute, chronic

10-15 days

Encephalomyelitis, generalized, moderately severe.

2 days

1-15-50

2-5

Encephalomyelitis, acute, chronic

VA Hospital, Port of Spain, B.A. 1-15-50

J. L. SNEY, R.D.

Washington National

1800 Dupont St., N.W., Wash., D.C.

9002

CERTIFICATE OF DEATH

Reg. Dist. No.

08978

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last Franklin				4. DATE OF DEATH Month 8 Day 31 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Carpenter Ret 5 yrs			10b. KIND OF BUSINESS OR INDUSTRY Maryland			11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Charles Franklin			14. MOTHER'S MAIDEN NAME Margaret O'Riley				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 716-01-9343		17. INFORMANT Mrs Anna Connors North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 30 hrs. 1 yr (?)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Allergic Bronchial Asthma							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan , 19 52 , to 31 Aug , 19 59 , that I last saw the deceased alive on 31 Aug , 19 59 , and that death occurred at 11:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 1 Sept '59							
ACTUAL SIGNATURE Klaus H. Huchner M.D.				PHYSICIAN'S NAME (Type) Klaus H. Huchner A.I.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 3, 1959		22c. NAME OF CEMETERY OR CREMATORY North East Methodist		22d. LOCATION (City, town, or county) (State) North East Cecil, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0003

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		COUNTY [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX AT BIRTH [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		MARITAL STATUS [Illegible]	
PREVIOUS ILLNESS [Illegible]		PRESENT ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]	
PHYSICIAN'S SIGNATURE [Illegible]		COUNTY HEALTH OFFICER'S SIGNATURE [Illegible]		DEATH CERTIFICATE NO. [Illegible]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness or injury. It is to be filed with the local health department or the State Department of Health. It is also to be furnished to the funeral home or other person in charge of the funeral. It is to be retained by the local health department or the State Department of Health for a period of ten years.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9017 Items 8, 9, Film G249 9-28-59 et

CERTIFICATE OF DEATH

08979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural				c. LENGTH OF STAY IN 1b 7yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Josephine Tomlinson Hallock				4. DATE OF DEATH Month Aug. Day 20 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/1882/ 1878	
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Burks Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Retired				10b. KIND OF BUSINESS OR INDUSTRY Own home			
13. FATHER'S NAME Lewis K. Tomlinson				14. MOTHER'S MAIDEN NAME Emily J. Newlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 205-284781			
17. INFORMANT Mrs. Blanche T. Gyles				Address Rising Sun, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis & Pericarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5:45 , 19 58 , to 8:20 , 19 58 , that I last saw the deceased alive on 8-19 , 19 58 , and that death occurred at 8:20 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 8/20/58 ACTUAL SIGNATURE G. H. Richards, Jr. M.D. PHYSICIAN'S NAME (Type) G. H. Richards, Jr. Port Deposit, Md. 8/20/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug. 24, 1959			
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.				22d. LOCATION (City, town, or county) (State) Rising Sun, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMillen				24a. REC'D BY REGISTRAR DATE AUG 24 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9003

CERTIFICATE OF DEATH

Reg. Dist. No.

08980

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS 466 Parkway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna D Middle Last Hartnett				4. DATE OF DEATH Month August Day 11 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 26, 1895	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk		10b. KIND OF BUSINESS OR INDUSTRY Conowingo Pr. Co.	
11. BIRTHPLACE (State or foreign country) Childs, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Hartnett		14. MOTHER'S MAIDEN NAME Mary E. Beers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-1808		17. INFORMANT Miss Bessie C. Hartnett, 466 Parkway, Elkton, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident Recurrent DUE TO Atherosclerotic Disease - Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Epilepsy - Cerebral Damage (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 5 days 15 yrs 8 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1951, 19 to 11 Aug 1959, that I last saw the deceased alive on 11 August 1959, and that death occurred at 12:59 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Plumer, Jr. M.D.				ADDRESS (Street, city or town, state) Elkton, Ind. DATE SIGNED 8/11/59			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-59		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem		22d. LOCATION (City, town, or county) (State) Elkton, Cecil Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Grant Funeral Home				24a. RECEIVED BY REGISTRAR DATE AUG 14 '59		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

9003

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1918	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		RACE [Illegible]	
PLACE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		TIME OF EXAMINATION [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF EXAMINER [Illegible]	
CERTIFICATE NO. [Illegible]		COUNTY [Illegible]	
CITY [Illegible]		STATE MARYLAND	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Wilhelminia C. Hunsberger		4. DATE OF DEATH August 25 19 59	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	9. AGE (In years last birthday) 71 yrs.
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adolph Martin		14. MOTHER'S MAIDEN NAME Wilhelmina Schneitman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Hospital to Record Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X CARDIOVASCULAR FAILURE DUE TO (b) LEFT VENTRICULAR FAILURE (PULM. EDEMA) 16 days DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 30 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-10-1959, to 8-25-1959, that I last saw the deceased alive on 8-25-1959, and that death occurred at 6:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Luis M. Cuza		M.D. Cecil are	
PHYSICIAN'S NAME (Type) Luis M. Cuza		North East, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-29-1959	22c. NAME OF CEMETERY OR CREMATORY Plains Memorial Cmn.	22d. LOCATION (City, town, or county) (State) Lansdale, Penna
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home, W.A. Lusby, Elkton, Md.		24a. REC'D BY REGISTRAR DATE AUG 27 '59	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR WATERING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100

DECEASED'S NAME [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]		SOCIAL HISTORY [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF JURY [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



This certificate is to be filled out by the coroner or physician in charge of the death. It is to be filed in the office of the coroner or physician in charge of the death. It is to be filed in the office of the coroner or physician in charge of the death. It is to be filed in the office of the coroner or physician in charge of the death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,22b Film G247 8-26-59 et

9005

CERTIFICATE OF DEATH

Reg. Dist. No. 08982

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>14 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEVINE NURSING HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>E</u> Last <u>HYLAND</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 26 1863</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRESS MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABSOLOM HYLAND</u>		14. MOTHER'S MAIDEN NAME <u>ANN GOLT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Annie Wilson North East, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Osteomyelitis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/28</u> , 19 <u>59</u> , to <u>8/Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11 Aug</u> , 19 <u>59</u> , and that death occurred at <u>10:57 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>George P. [Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HART'S METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>North East Cecil, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	
ADDRESS <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. [Signature]</u>	

CERTIFICATE OF DEATH

0000

1918

REG. DIST. NO.

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
NAME OF PHYSICIAN [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
NAME OF NEXT OF KIN [Illegible]		NAME OF SURVIVOR [Illegible]		NAME OF WITNESS [Illegible]	
NAME OF REGISTRAR [Illegible]		NAME OF CLERK [Illegible]		NAME OF JUDGE [Illegible]	

9018

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.F.D.1				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Elkton R.F.D.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Moseback Farm				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ella Mae Keffer				4. DATE OF DEATH Month Day Year 8 16 19 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-46		9. AGE (In years last birthday) 12 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School Girl		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leroy Keffer				14. MOTHER'S MAIDEN NAME Sadie Dalton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Sadie Dalton Keffer, Elkton R.D.1.Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 9298 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went in bathing in Elk River					
20c. TIME OF INJURY Month, Day, Year Hour m. 8 16 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk River		20f. (City or town) (County) (State) Elkton R.D. Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 8-17-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 18, 1959		22c. NAME OF CEMETERY OR CREMATORY White Church Cemetery		22d. LOCATION (City, town, or county) (State) Fincastle Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pippin Funeral Home				24a. REC'D BY REGISTRAR ADDRESS 259 E. Main St. ELKTON, Md.		24b. REGISTRAR'S SIGNATURE DATE AUG 19 1959	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on delay is made, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9019 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.F.D. 1</u> c. LENGTH OF STAY IN 1b <u>5yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.F.D. 1</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Keffer</u> Last <u>Keffer</u>			4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>19 59</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>6-15-1925</u>		9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____			
11. IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Thiokol</u>			
11. BIRTHPLACE (State or foreign country) <u>Cane brake W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Essie Ola Keffer</u>			
14. MOTHER'S MAIDEN NAME <u>Icie Ganer Crowder</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>231-24-4987</u>			
17. INFORMANT <u>Sadie Keffer, Elkton, R.D. 1, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went to rescue pf daughter in Elk. River</u>					
20c. TIME OF INJURY Month, Day, Year <u>8-16-59</u> Hour <u>5:55</u> a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Elk River</u>			
20f. (City or town) <u>Elkton, r.f.d. Cecil Md.</u>		20g. (County) <u>Cecil</u>		20h. (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>8-17-59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Church Cem.</u>			
22d. LOCATION (City, town, or county) <u>Fincastle Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Pippin</u>		24a. REC'D BY REGISTRAR <u>Aug 19 59</u>			
23. ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Pippin</u>		24c. ADDRESS <u>259 E. Main St.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on delay is necessary, please enclose certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

0020

CERTIFICATE OF DEATH

Death

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

1-18-95

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

VA

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

John J. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on delay is necessary, please execute a separate certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the coroner. Give Page 5 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9006

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pa. b. COUNTY Delaware			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essington		75x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 514 Saude, Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Estella Gertrude Kline				4. DATE OF DEATH Month 8 Day 1 Year 59			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houswife		10b. KIND OF BUSINESS OR INDUSTRY House keeping		11. BIRTHPLACE (State or foreign country) Reading, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Gesberg				14. MOTHER'S MAIDEN NAME Clara Englehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT George Kline, 514 Saude Ave Address Essington, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary, Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-1-59		22c. NAME OF CEMETERY OR CREMATORY LAWN CROFT CEMETERY		22d. LOCATION (City, town, or county) (State) MARCUS HOOK, PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS ELKTON MD		24a. REC'D BY REGISTRAR AUG 4 59	
				24b. REGISTRAR'S SIGNATURE Carlton J. Frank			

9021

CERTIFICATE OF DEATH

08987

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2504 10th St., N.E.	
3. NAME OF DECEASED (Type or print) First EMORY Middle J. Last KNUDSEN		4. DATE OF DEATH Month August Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1888
9. AGE (In years lost birthday) 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT WW-I		Address Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 25, 19 53 , to Aug. 21, 19 59 , and that death occurred at 10:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-23-59			
ACTUAL SIGNATURE J. L. Garey		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/26/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Remington & Son		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR SEP 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Page 4

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by a physician, hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

9021

DEPARTMENT OF COMMERCE

DEPT. OF COMMERCE

Washington

Severely Injured

Severely Injured

2501 10th St., N.E.

Veteran's Administration Hospital

1

20

21

August

1943

1

2000

17

August 12, 1943

1

White

10

USA

Unknown

Unknown

Unknown

Unknown

Unknown

Hospital Records, V.A., Perry Point, Md.

Unknown

10-1

10

3 to 4 Days

Pneumonia, bilateral, unresolved

Interlobar, localized, severe

X

Nov. 22, 1943

Nov. 22, 1943

Official Certificate

J. L. Smith, M.D.

Virginia

Ft. Myer

Arlington Hospital

General

Leave Doctor, Md.

1494 1
 9022 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 8,9 FilmG246 8-25-59 et
 CERTIFICATE OF DEATH

08988

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 24yrs.6mo.5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2739 Huntington Avenue	
3. NAME OF DECEASED (Type or print) First WILLIE Middle S. Last MASON		4. DATE OF DEATH Month August Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-93 1895
9. AGE (In years last birthday) 64 6/6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mason		14. MOTHER'S MAIDEN NAME Mary Mayo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Not obtain-able	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with old infarct DUE TO right ventricle & mural thrombus within right ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary infarction secondary to #1 (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 9, 1935 , to August 14, 1959 , and that death occurred at 12:50a , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Goldgraben		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-14-59	
PHYSICIAN'S NAME (Type) S. GOLDGRABEN		Chief, Medical Service	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/17/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		24a. REC'D BY REGISTRAR ADDRESS Havre de Grace, Md.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE AUG 24 '59	

Page 4
 The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the attending physician and completely filled in by the funeral director. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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250

120

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52-52-7

01.05.2017

adipose

100-443887-100

9025

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pa. b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkside 75 x -3	
c. LENGTH OF STAY IN 1b Visiting		d. STREET ADDRESS 204 W. Shelton Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joan Middle Marie Last Moyer		4. DATE OF DEATH Month 8 Day 1 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8-6-1943	9. AGE (In years last birthday) 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Girl		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chester, Pa.
13. FATHER'S NAME Douglas Moyer		14. MOTHER'S MAIDEN NAME Marie Mullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Douglas Moyer, 204 W. Shelton, Rd.		Address Parkside, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Could not swim and went into a hole	
20c. TIME OF INJURY Month 8 Day 1 Year 19 59 Hour 4 a. m. — p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sassafas River Earville Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		DATE SIGNED 8-1-59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Removal August 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Chester Rural Cemetery	22d. LOCATION (City, town, or county) (State) Chester, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow		24a. REC'D BY REGISTRAR DATE AUG 6 '59	
ADDRESS Middletown Md.		24b. REGISTRAR'S SIGNATURE Richard L. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is required, please execute and forward to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9024

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alleghany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>910 Wallace Obenshain, MD Main St.</u>				d. STREET ADDRESS <u>317 Hawthorne St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Armitta</u> Middle <u>May</u> Last <u>Obenshain</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 30, 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Yadkin County, NC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Franklin May</u>		14. MOTHER'S MAIDEN NAME <u>Alice Jane Garner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Wallace Obenshain, M.D. Cecilton.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Erosion of Aorta</u> DUE TO (c) <u>Carcinoma of Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 minutes</u> <u>1 month?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral metastases</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 12, 1958</u> to <u>Aug 6, 1959</u> , that I last saw the deceased alive on <u>Aug 6, 1959</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain, M.D. Cecilton, MD.</u>				DATE SIGNED <u>6 Aug 59</u>			
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D. Cecilton, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Aug. 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Corington VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Yellow Millington MD</u>				ADDRESS <u>Corington VA.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be obtained by a hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9025 Items 3,5 FilmG248 9-3-59 et
CERTIFICATE OF DEATH

08991

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural				c. LENGTH OF STAY IN 1b 13 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Correct) Maryan Rahelich Sr. (Type or print) First Middle Last				4. DATE OF DEATH 8- 26 1959 Month Day Year			
5. SEX (Correct) Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Foreman				10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ludwig Rahelich				14. MOTHER'S MAIDEN NAME Mary ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 097-09-04-65		17. INFORMANT Mrs Jenny Rahelich, Sr. North East (Rural) Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 Aug 1959 , to 26 Aug 1959 , that I last saw the deceased alive on 26 Aug 1959 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East Rd DATE SIGNED 28 Aug '59 ACTUAL SIGNATURE Klaus H. Huchner M.D. Klaus H. Huchner M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-59		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant ADDRESS Northeast Md				24a. REC'D BY REGISTRAR DATE AUG 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

9025

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCASION OF DEATH [Illegible]		PREVIOUS ILLNESS [Illegible]		PREVIOUS SURGERY [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

CRIMINAL RECORDS
 BALTIMORE, MARYLAND
 DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS
 100 NORTH EIGHTH STREET
 BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08992

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2142 Walbrook Avenue					
3. NAME OF DECEASED (Type or print) First WILLIAM Middle O. Last ROSS				4. DATE OF DEATH Month August Day 10 Year 19 59					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH 3-21-23		9. AGE (In years last birthday) 36 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Days								
Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland					
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Joseph R. Ross				14. MOTHER'S MAIDEN NAME Frances Carla					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-18-3609		17. INFORMANT Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Waded in Susquehanna River, Perry Point, Cecil Co. Md.							
20c. TIME OF INJURY Month, Day, Year 1:30 p.m. 8-10 19 59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River Perry Point, Cecil, Md.					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R. C. Dodson</i>		EXAMINER'S NAME (Type) R. C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/12/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore National					
22d. LOCATION (City, town, or county) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.							
24a. REC'D BY REGISTRAR DATE AUG 13 '59		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Lewis</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is for the funeral director, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the funeral director. Give Page 6 to the funeral director. Give Page 7 to the funeral director. Give Page 8 to the funeral director. Give Page 9 to the funeral director. Give Page 10 to the funeral director. Give Page 11 to the funeral director. Give Page 12 to the funeral director. Give Page 13 to the funeral director. Give Page 14 to the funeral director. Give Page 15 to the funeral director. Give Page 16 to the funeral director. Give Page 17 to the funeral director. Give Page 18 to the funeral director. Give Page 19 to the funeral director. Give Page 20 to the funeral director. Give Page 21 to the funeral director. Give Page 22 to the funeral director. Give Page 23 to the funeral director. Give Page 24 to the funeral director. Give Page 25 to the funeral director. Give Page 26 to the funeral director. Give Page 27 to the funeral director. Give Page 28 to the funeral director. Give Page 29 to the funeral director. Give Page 30 to the funeral director. Give Page 31 to the funeral director. Give Page 32 to the funeral director. Give Page 33 to the funeral director. Give Page 34 to the funeral director. Give Page 35 to the funeral director. Give Page 36 to the funeral director. Give Page 37 to the funeral director. Give Page 38 to the funeral director. Give Page 39 to the funeral director. Give Page 40 to the funeral director. Give Page 41 to the funeral director. Give Page 42 to the funeral director. Give Page 43 to the funeral director. Give Page 44 to the funeral director. Give Page 45 to the funeral director. Give Page 46 to the funeral director. Give Page 47 to the funeral director. Give Page 48 to the funeral director. Give Page 49 to the funeral director. Give Page 50 to the funeral director. Give Page 51 to the funeral director. Give Page 52 to the funeral director. Give Page 53 to the funeral director. Give Page 54 to the funeral director. Give Page 55 to the funeral director. Give Page 56 to the funeral director. Give Page 57 to the funeral director. Give Page 58 to the funeral director. Give Page 59 to the funeral director. Give Page 60 to the funeral director. Give Page 61 to the funeral director. Give Page 62 to the funeral director. Give Page 63 to the funeral director. Give Page 64 to the funeral director. Give Page 65 to the funeral director. Give Page 66 to the funeral director. Give Page 67 to the funeral director. Give Page 68 to the funeral director. Give Page 69 to the funeral director. Give Page 70 to the funeral director. Give Page 71 to the funeral director. Give Page 72 to the funeral director. Give Page 73 to the funeral director. Give Page 74 to the funeral director. Give Page 75 to the funeral director. Give Page 76 to the funeral director. Give Page 77 to the funeral director. Give Page 78 to the funeral director. Give Page 79 to the funeral director. Give Page 80 to the funeral director. Give Page 81 to the funeral director. Give Page 82 to the funeral director. Give Page 83 to the funeral director. Give Page 84 to the funeral director. Give Page 85 to the funeral director. Give Page 86 to the funeral director. Give Page 87 to the funeral director. Give Page 88 to the funeral director. Give Page 89 to the funeral director. Give Page 90 to the funeral director. Give Page 91 to the funeral director. Give Page 92 to the funeral director. Give Page 93 to the funeral director. Give Page 94 to the funeral director. Give Page 95 to the funeral director. Give Page 96 to the funeral director. Give Page 97 to the funeral director. Give Page 98 to the funeral director. Give Page 99 to the funeral director. Give Page 100 to the funeral director.

39120

1935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1935		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Burial		Name of Burial Place	
Jan 16, 1935		Cemetery		Lot 10	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9027
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Orange	
3. NAME OF DECEASED (Type or print) First Martha Middle Putman Last Rowland		4. DATE OF DEATH August 12 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1866
9. AGE (In years at birthday) 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Waterbury, Conn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin A. Putman		14. MOTHER'S MAIDEN NAME Cornelia Van Deren	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Edwin J. Schwaubasser, North East, Md.		Address (Hances Point)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) arterio-sclerotic Cardio Vascular Disease (c) Generalized Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 15 minute Years. Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of hip.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Louis M. Cuza		M.D. Cecil A. [unclear]	
PHYSICIAN'S NAME (Type) LUIS M. CUZA		North East, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-13-59	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant Funeral Home, North East, Md.		24a. REC'D BY REGISTRAR DATE AUG 17 '59	24b. REGISTRAR'S SIGNATURE Carlton E. Kraus

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be filed with the funeral director, who will be responsible for its use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar for burial, cremation, or removal, or in any event within 72 hours after death.

At

1
 9007
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

08994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard H. Schaffer		4. DATE OF DEATH August 25 1959	
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1869
9. AGE (In years lost birthday) 90		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Schaffer		14. MOTHER'S MAIDEN NAME Molly No Information	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-22-6282	
17. INFORMANT Harlan L. Schaffer		2312 Morris St. Kiamensi Gardens	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Renal and Heart Failure 10 days after surgery (Prostatectomy). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Diffuse Adenocarcinoma of Prostate (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/13, 1959, to 8/25, 1959, that I last saw the deceased alive on Aug 24, 1959, and that death occurred at 4:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James Maurice M.D. 265 W. Main St. Elkton Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL Burial	22b. DATE THEREOF 8-28-1959	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	22d. LOCATION (City, town, or county) (State) Elkton Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. B. Pippin		24a. REC'D BY REGISTRAR DATE AUG 27 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

CERTIFICATE OF DEATH

9007

11-11

1907

11-11-1907

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11-11-1907

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 24 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbur Middle Scott Last				4. DATE OF DEATH Month 8 Day 27 Year 19 59			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G Labor		10b. KIND OF BUSINESS OR INDUSTRY Any labor		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Scott				14. MOTHER'S MAIDEN NAME Rebecca			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-10-0097		17. INFORMANT Wilbur Scott, Jr. Cecilton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Ecephalo Malaria 332x DUE TO Arterio sclerosis Vascular disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 8-29-1959	
EXAMINER'S NAME (Type) R.C. Dodson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-31-59		22c. NAME OF CEMETERY OR CREMATORY Cecilton		22d. LOCATION (City, town, or county) (State) Cecilton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Howard				24a. REC'D BY REGISTRAR DATE SEP 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

9028

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10yrs9mos5days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		0352.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 214 B Suter Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle B. Last SMITH		4. DATE OF DEATH Month August Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1899
9. AGE (In years lost birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus with metastases 150 X DUE TO to liver and abdominal nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe			
INTERVAL BETWEEN ONSET AND DEATH unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1948 , to August 29, 1959 , and that death occurred at 3:33 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-31-59			
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 8-31-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/3/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Remington J. Sog</i>		ADDRESS Havre DeGrace, Md.	
24a. REC'D BY REGISTRAR DATE SEP 4 '59		24b. REGISTRAR'S SIGNATURE <i>Charles E. K...</i>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

9029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4th + George sts.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>B</u> Middle <u>Frank</u> Last <u>Stevens</u>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			

13. FATHER'S NAME <u>George W. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Knotts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT Address <u>Mrs Frank Stevens Chesapeake</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Carcinoma of Prostate</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 year</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>March 10, 1958</u> , to <u>Aug 3, 1959</u> , that I last saw the deceased alive on <u>Aug 3, 1959</u> , and that death occurred at <u>11:55 AM</u> from the causes and on the date stated above.		DATE SIGNED <u>8/3/59</u>
ACTUAL SIGNATURE <u>Henry V. Davis</u> M.D.		
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u> <u>CHESAPEAKE CITY MD</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bethel Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Boeuf</u> ADDRESS <u>Edenton, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0082

CERTIFICATE OF DEATH

0000

1

9009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union				d. STREET ADDRESS 102 Douglas Street			
3. NAME OF DECEASED (Type or print) NERVIE First LOU Middle STEVENSON Last				4. DATE OF DEATH August 29, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Austin Sparks				14. MOTHER'S MAIDEN NAME Mary Shelton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-34-4605		17. INFORMANT George M. Stevenson		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.2 Arteriosclerotic cardiovascular disease DUE TO with severe angina pectoris Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1957, to August 29, 1959, that I last saw the deceased alive on August 29, 1959, and that death occurred at 4 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 8/30/59	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton		Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR DATE SEP 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY District of Columbia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1522 E. Capitol Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR L. THREATT		First		Middle		Last		4. DATE OF DEATH Month August		Day 6,		Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/17		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment operator		10b. KIND OF BUSINESS OR INDUSTRY Equipment		11. BIRTHPLACE (State or foreign country) Everson, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Russell Threatt		14. MOTHER'S MAIDEN NAME Unknown													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Unknown		Address Hospital Records, VAH, Perry Point, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abdominal carcinomatosis. DUE TO (c) Carcinoma of the stomach, infiltrating type.		INTERVAL BETWEEN ONSET AND DEATH 2-3 days													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 7/22 , 19 59 , to 8/6 , 19 59 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. V. A. Hospital, Perry Point, Md. (Street, city or town, state)		DATE SIGNED													
ACTUAL SIGNATURE JAMES L. GAREY, M. D.		M.D. Clinical Pathologist													
PHYSICIAN'S NAME (Type) James L. Garey															
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/10/59		22b. DATE THEREOF Unknown		22c. NAME OF CEMETERY OR CREMATORY Washington D.C.		22d. LOCATION (City, town, or county) (State) Washington D.C.									
23. FUNERAL DIRECTOR'S SIGNATURE James L. Garey		ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR AUG 13 59		24b. REGISTRAR'S SIGNATURE William L. Frank									

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1150

51/02/2

9031

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Berks</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading Penna</u> 75X.3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>Rd 2</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Diane Louise Wahl</u>			4. DATE OF DEATH Month Day Year <u>August 28 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1955</u>		9. AGE (In years last birthday) <u>4 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Reading Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Albert Wahl</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Esther Gueringer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>William A. Wahl</u> Address <u>Rd 2 Reading Penna</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u> DUE TO 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>929.8</u> DUE TO (c) <u>929.8</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>929.8</u> INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walked into deep water</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>1 8 28 19 59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>North East Cecil Co, Maryland</u>	
20f. (City or town) (County) (State) <u>North East Cecil Co, Maryland</u>					
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-28-1959</u>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8-28-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Temple Berks Pa</u>		22d. LOCATION (City, town, or county) (State) <u>Temple Berks Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Hunt</u>		ADDRESS <u>North East, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. L. Hunt</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9032

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3 mo. 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 503 D Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD (NMI) WATSON		4. DATE OF DEATH Month Day Year August 25 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-09
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Not obtainable	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary (?) Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Not obtainable	
INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning (clinical) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive cardio-vascular renal disease DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 30 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 19 59 to August 25, 19 59 and that death occurred at 11.50am from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 8-28-59			
ACTUAL SIGNATURE J. L. Garey		PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/29/59	
22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Prospect, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE SEP 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0032

Death

Death Date

3 no. 21 Ave

Washington

Washington, D.C.

203 7 Street, S.W.

(M-1)

11-2-40

Male

White

Not Specified

Illness

Unknown

Part (1) Unknown

Part II

Not Specified - Hospital Record, Vol. 1, Part 1, 1939

Chronic, acute, terminal (terminal)

10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

Unknown - acute - terminal - 10 days

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9033

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09002

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 42 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2410 Annapolis Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROGER Middle E. Last WILLIAMS		4. DATE OF DEATH Month August Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-36
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months 22	IF UNDER 24 HRS. Hours 12 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Luther Williams	
14. MOTHER'S MAIDEN NAME Minnie Hill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 975x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide by drowning.	
20c. TIME OF INJURY Month, Day, Year 8:05 a.m. 8-12 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River, Perry Point, Cecil, Maryland		20f. (City or town) (County) (State) Baltimore, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON		DATE SIGNED 8-12-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/14/59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Maryland		24a. REC'D BY REGISTRAR AUG 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

9010

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil Ct. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE E. Orange, N.J. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chester Middle Abraham Last L. Womack		4. DATE OF DEATH Month 8/20 Day 19 Year 59	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 28 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Abraham L. Womack, Sr.		14. MOTHER'S MAIDEN NAME Virginia Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Naomi Womack-192 Century Ave., East Orange, N.J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture upper eleven ribs right side, hemomata 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Punctured right lung DUE TO (c) 9 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident on route 1 Near Belair, Maryland	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 1.30 xxx 8/11 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Bel Air, Md Rt. 1 Harford Ct. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/23/59	
22c. NAME OF CEMETERY OR CREMATORY Furgerson Cem.		22d. LOCATION (City, town, or county) (State) Prospect, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Bell		ADDRESS 909 Poplar St. Wilm. Del.	
24a. REC'D BY REGISTRAR AUG 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

065

12

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



9011

CERTIFICATE OF DEATH

Reg. Dist. No.

09004

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN b. 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kate Middle Virginia Last Worth		4. DATE OF DEATH Month August Day 10 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1867
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months 10 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Elk Neck, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William A. Pryor	
14. MOTHER'S MAIDEN NAME Mary Barr		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Mary Lair, Landenberg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 18, 1956 , to August 10, 1959 , that I last saw the deceased alive on August 5, 1959 , and that death occurred at 4:55a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 8/11/59	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 13, 1959	22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.	22d. LOCATION (City, town, or county) (State) North East, Cecil Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE GRANT FUNERAL HOME ADDRESS NORTH EAST, Md.		24a. REC'D BY REGISTRAR AUG 14 '59 24b. REGISTRAR'S SIGNATURE Charles E. H.	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3011

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
DATE OF BIRTH (Month, day, year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If deceased was engaged in any occupation, trade, or profession, state it)		CAUSE OF DEATH (State immediately and briefly the cause of death)	
PLACE OF DEATH (City, State, Country)		MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal, Undetermined)	
DATE OF DEATH (Month, day, year)		TIME OF DEATH (Hour, minute)	
SIGNATURE OF DECEASED (If deceased was capable of signing)		SIGNATURE OF WITNESSES (Two persons who were present at the death)	
SIGNATURE OF PHYSICIAN (If deceased was under medical treatment)		SIGNATURE OF CORONER (If death was sudden or unexpected)	
SIGNATURE OF REGISTRAR (If death was reported to the Registrar)		SIGNATURE OF CLERK (If death was reported to the Clerk)	

Handwritten signature

1. This certificate is to be filled out by the physician, coroner, or registrar, as the case may be, who is present at the death of the deceased.

2. The cause of death should be stated in full, and the manner of death should be stated in full.

3. The date of death should be stated in full, and the time of death should be stated in full.

4. The place of death should be stated in full.

5. The occupation of the deceased should be stated in full.

6. The name of the deceased should be stated in full.

7. The sex of the deceased should be stated in full.

8. The date of birth of the deceased should be stated in full.

9. The place of birth of the deceased should be stated in full.

10. The signature of the deceased, if any, should be stated in full.

11. The signature of the witnesses, if any, should be stated in full.

12. The signature of the physician, coroner, or registrar, if any, should be stated in full.

13. The signature of the clerk, if any, should be stated in full.